

JUDGE SHADUR

MAGISTRATE JUDGE NOLAN

3006724-RTV

EDA

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

HARTFORD UNDERWRITERS
INSURANCE COMPANY, a Connecticut
Corporation

Plaintiff,

v.

W MANAGEMENT, INC., a N.J.
corporation, and DANIEL WALDMAN,
individually,

Defendants.

Case No:

COMPLAINT FOR DECLARATORY JUDGMENT

Plaintiff, HARTFORD UNDERWRITERS INSURANCE COMPANY (“Hartford”), by its attorneys, SmithAmundsen, LLC, pursuant to 28 U.S.C. §§ 2201 and 2202, for its Complaint for Declaratory Judgment against Defendants, W MANAGEMENT, INC. (“W Management”) and DANIEL WALDMAN (“Waldman”), states as follows:

JURISDICTION

1. The jurisdiction of the court is premised upon 28 U.S.C. §1332 in that there is complete diversity of citizenship between the parties and the amount in controversy exceeds the sum of \$75,000, exclusive of interest and costs.

VENUE

2. Venue is premised upon 28 U.S.C. §1391 in that a substantial part of the events or omissions giving rise to this suit occurred in this District.

THE PARTIES

3. At all times relevant hereto, Hartford was a Connecticut corporation, with its principal place of business located in Hartford, Connecticut. Hartford issued a Workers Compensation/Employer's Liability policy to its insured, W Management, Inc., as will be detailed herein.

4. On information and belief, at all times relevant hereto, W Management was a corporation, formed under the laws of the State of New Jersey. On information and belief, at all times relevant hereto, W Management's principal place of business was New Jersey.

5. At all times relevant hereto, Daniel Waldman was a natural person who is a citizen of New Jersey and resides at 1512 Palisades Avenue, Fort Lee, NJ 07024. On information and belief, Waldman is the President of W Management. Waldman has made a claim for workers compensation benefits against W Management in the Illinois Workers Compensation Commission ("IWCC") for injuries he allegedly sustained in Chicago, Illinois on May 21, 2004, when he was struck by an auto, while allegedly in the course of his employment for W Management.

WALDMAN'S ILLINOIS APPLICATION FOR ADJUSTMENT OF CLAIM

6. On or about December 16, 2004, Waldman filed an Application for adjustment of claim against W Management in the IWCC, arising from the injuries he

claims to have sustained on May 21, 2004, Case No. 04 WC 59623 (“the Waldman Application”). A copy of the Waldman Application is attached hereto and incorporated herein as Exhibit “A.”

7. The Waldman Application states that the “location of the accident” was “Chicago, IL.” *See* Exhibit A.

8. Mr. Waldman’s residence is shown on the Application as “1512 Palisades Avenue, Fort Lee, NJ 07024.” *See* Exhibit A.

9. W Management’s address is shown on the Application as “580 Sylvan Avenue, Englewood Cliffs, NJ 07632.” *See* Exhibit A.

10. The Waldman Application claims that Mr. Waldman was paid an average weekly wage of \$6,000 by W Management. *See* Exhibit A.

11. Counsel for Mr. Waldman recently forwarded the Waldman Application to Hartford’s claims administrator for defense and indemnity.

THE HARTFORD POLICY

12. Hartford issued a Workers Compensation/Employer’s Liability policy to W Management Inc., policy number 6S60UB 9589A893 (“the Hartford policy”). The Hartford policy was effective from April 17, 2004 to April 17, 2005. A true and complete copy of the Hartford policy is attached hereto as Exhibit B.

13. Item 1 of the Information Page of the Hartford policy shows a location for W Management, Inc. in Englewood, New Jersey. *See* Exhibit B.

14. Item 1 of the Information Page also shows that the insurance producer was “America S Insurance Center” of Springfield, New Jersey. *See* Exhibit B.

15. The Information Page provides in relevant part as follows:

3. **A. WORKERS COMPENSATION INSURANCE:** Part One of the policy applies to the Workers Compensation Law of the state(s) listed here:

NJ

* * *

- C. **OTHER STATES INSURANCE:** Part Three of the policy applies to the states, if any, listed here:

COVERAGE EXCLUDED.

* * *

16. The terms of the Hartford policy further provide as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

* * *

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page.

* * *

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page;¹ and it covers all other workplaces in Item 3.A. States ...

¹ No locations are listed in Item 4 of the Information Page.

* * *

PART ONE – WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death....

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance...

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

* * *

PART TWO – EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

This employer's liability insurance applies to bodily injury by accident or bodily injury by disease.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.

* * *

B. We Will Pay

We will pay all sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered but his Employers Liability Insurance.

* * *

C. Exclusions

This insurance does not cover:

4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;

* * *

PART THREE – OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information page.

* * *

PART FOUR –YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

* * *

3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.

* * *

17. When the Hartford policy was transmitted to W Management, it included a “Notice to Policy Holders” form which provided as follows:

IF YOU HAVE EMPLOYEES WHO TRAVEL OR WORK OUT OF STATE, YOU MAY NEED ADDITIONAL WORKERS’

COMPENSATION INSURANCE. CONSULT YOUR INSURANCE ADVISOR OR CARRIER PRIOR TO COMMENCEMENT OF OPERATIONS IN ANY STATE NOT LISTED ON YOUR POLICY.

* * *

**HARTFORD'S PAYMENT OF BENEFITS AND REQUEST FOR
WITHDRAWAL OF THE WALDMAN APPLICATION**

18. Waldman has previously received benefits, paid under the Hartford Policy pursuant to the terms of the New Jersey Workers Compensation Act.

19. On or about May 6, 2008, counsel for Hartford sent a letter to Waldman's counsel, informing him that the Hartford policy did not provide coverage for the Waldman Application, and requested that Waldman withdraw the Waldman Application in the IWCC and pursue further benefits under New Jersey law.

20. Thereafter, Hartford's counsel was informed by Waldman's counsel that the claim in the Waldman Application would not be withdrawn.

PRAYER FOR RELIEF

21. Hartford owes no duty to defend or indemnify W Management with respect to the Waldman Application under Part One of the Hartford policy because the Hartford policy provides workers compensation insurance that applies only to claims filed in the 3.A. state, New Jersey, for benefits under the New Jersey Workers Compensation Law, and the Waldman Application was filed in the IWCC, seeking benefits under the Illinois Workers Compensation Law.

22. Hartford owes no duty to defend or indemnify W Management with respect to the Waldman Application under Part One of the Hartford policy because

Waldman's claimed injuries were not sustained at a covered location or workplace in the 3.A. state of New Jersey.

23. Hartford owes no duty to defend or indemnify W Management with respect to the Waldman Application under Part Two of the Hartford policy because Part Two expressly excludes coverage for any obligation imposed by a workers compensation law.

24. Hartford owes no duty to defend or indemnify W Management with respect to the Waldman Application under Part Three of the Hartford policy because coverage is expressly excluded, and no other states are shown, in item 3C of the Information Page.

25. In the alternative, and without prejudice to the positions set out previously, W Management's 3 year delay in providing notice to Hartford of the Waldman Application violates Part Four of the Hartford policy and relieves Hartford of any duties it would otherwise have owed to W Management or Waldman with respect to the Waldman Application.

26. An actual and justiciable controversy exists between the parties hereto and pursuant to 28 U.S.C. §§ 2201 and 2202 this court is granted the power to determine and adjudicate the rights and obligations of the parties hereto.

WHEREFORE, for the reasons stated hereinabove, Hartford prays that this Court enter judgment finding and declaring that Hartford owes no duty to defend or indemnify W Management with respect to the Waldman Application, declaring that Mr. Waldman is entitled to no right, title or interest in the Hartford policy as a judgment creditor of W

Management with respect to recovery, if any, he makes in connection with the Waldman Application or under the Illinois Workers Compensation Law, for such further relief as this Court deems just and equitable and for an award of Hartford's costs incurred herein.

HARTFORD UNDERWRITERS
INSURANCE COMPANY

By: s/Richard T. Valentino
One of Its Attorneys

Richard T. Valentino, Esq. (ARDC No. 6188317)
SMITHAMUNDSEN, LLC
150 N. Michigan Avenue, Ste. 3300
Chicago, IL 60601
Phone: (312) 894-3200
FAX: (312) 894-3210

MAGISTRATE JUDGE NOLAN

ILLINOIS INDUSTRIAL COMMISSION
APPLICATION FOR ADJUSTMENT OF CLAIM (APPLICATION FOR BENEFITS)

ATTENTION. Please type or print. Complete all questions. File three copies of this form.

Workers' Compensation Act ☒ Occupational Diseases Act ☐ Fatal case? No ☒ Yes ☐ Date of Death _____

DEC 16 2004

04WC 59623

Daniel Waldman
Employee/Petitioner

Case #
(Office use only)

Y.

W. Management Company
Employer/Respondent

Location of accident Chicago IL
or last exposure City State

Daniel Waldman 1512 Palisades Ave. Fort Lee NI 07024
Injured employee's name Street address City State Zip code

W. Management 580 Sylvan Ave. Englewood Cliffs NJ 07632
Employer's name Street address City State Zip code

Employee information: Social Security [REDACTED] Male ☒ Female ☐ Married ☐ Single ☒

Dependents under age 18 0 Birthdate [REDACTED] Average weekly wage \$ 6,000.00

Date of accident? 5/21/04 The employer was notified of the accident orally ☒ in writing ☒

How did the accident occur? Petitioner was Pedestrian struck by vehicle

What part of the body was affected? Both Arms and Legs - Multiple

What is the nature of the injury? Medical care is ongoing Return to work date? to be determined

Is a Petition for an Immediate Hearing attached? Yes ☐ No ☒

Is the injured employee currently receiving Temporary Total Disability benefits? Yes ☐ No ☒

If a prior application was ever filed for this employee, list the case number and its status NONE

ATTENTION, PETITIONER. This is a legal document. Be sure all blanks are completed correctly and you understand the statements before you sign this. Refer to the Commission's *Handbook on Workers' Compensation and Occupational Diseases* (4) for more information.

X Daniel Waldman
Signature of Petitioner

12-16-04
Date

[Signature]
Signature of attorney

APPEARANCE OF PETITIONER'S ATTORNEY
Please attach a copy of the Attorney Representation Agreement.

39 S. LaSalle Street, Suite 610
Street address

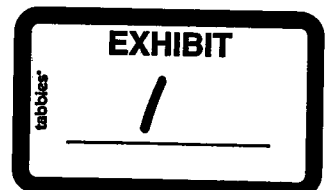
William M. Wippold (612)
Attorney's name and IIC attorney code number (5) (please print)

Chicago IL 60603
City State Zip Code

Dwyer, McCarthy & Associates, Ltd.
Firm name

(312) 782-7482
Telephone number

ICI 6/99 100 W. Randolph Street #8-200 Chicago, IL 60601 312/814-0611 Peoria 309/671-3019 Rockford 815/987-7292 Springfield 217/783-7094




PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.
If you prefer, you may submit the front of this application form with the *Proof of Service* on a separate page.

I, William M. Wippold, affirm that I mailed with proper postage in the City of Chicago,
Illinois a copy of this form at 5:00 p.m. on 12-16-04 to the respondent listed on this application and to
each additional party, if any, at the address listed below.
W. Management Company
580 Sylvan Ave.
Englewood Cliffs, NJ 07632

Hartford Underwriters Insurance Co.
PO Box 12647
Reading, PA. 19612-2647


Signature of person completing *Proof of Service*

Signed and Sworn to before me 1 1

Notary Public

- ¹ In most cases, the injured employee files this application and is referred to as the petitioner. If the injury was fatal, or if the worker is a minor or incapacitated, another person (as allowed by law) may file. In those cases, the person filing the application is the petitioner, and the worker is referred to as the injured employee
- ² This may be the date of the accident, last exposure disability, or death.
- ³ If the employee has not returned to work, leave this space blank.
- ⁴ The Industrial Commission publishes a handbook that explains the workers' compensation system. If you would like a copy, please call any of the Commission offices listed on the other side of this form.
- ⁵ The Industrial Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

08CV3283



JUDGE SHADUR

MAGISTRATE JUDGE NOLAN

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

A Custom Insurance Policy Prepared for:

W MANAGEMENT INC
580 SYLVAN AVE
ENGLEWOOD NJ 07632

WA005K00

EXHIBIT

tabbles
2



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

TYPE AR INFORMATION PAGE WC 00 00 01 (B)

POLICY NUMBER: (6S60UB-9589A89-3-04)

NJ TAX IDENTIFICATION NO.: 223769223000

NEW-04

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

NCCI CO CODE: 10456

1.

INSURED:

W MANAGEMENT INC
580 SYLVAN AVE
ENGLEWOOD NJ 07632

PRODUCER:

AMERICA S INS CENTER
25 ROUTE 22 E
SPRINGFIELD NJ 07081

Insured is A CORPORATION

Other work places and identification numbers are shown in the schedule(s) attached.

2. The policy period is from 04-17-04 to 04-17-05 12:01 A.M. at the insured's mailing address.

3. A. **WORKERS COMPENSATION INSURANCE:** Part One of the policy applies to the Workers Compensation Law of the state(s) listed here:

NJ

B. **EMPLOYERS LIABILITY INSURANCE:** Part Two of the policy applies to work in each state listed in item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident:	\$	1000000	Each Accident
Bodily Injury by Disease:	\$	1000000	Policy Limit
Bodily Injury by Disease:	\$	1000000	Each Employee

C. **OTHER STATES INSURANCE:** Part Three of the policy applies to the states, if any, listed here:

COVERAGE EXCLUDED.

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All required information is subject to verification and change by audit to be made **ANNUALLY**.

See extension of info page.

DATE OF ISSUE: 05-07-04 KL

ST ASSIGN: NJ

OFFICE: ORLANDO DA HTFD 05G

PRODUCER: AMERICA S INS CENTER

2B3BR



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

TYPE AR INFORMATION PAGE WC 00 00 01 (B)

POLICY NUMBER: (6S60UB-9589A89-3-04)

CLASSIFICATION SCHEDULE:

CLASSIFICATIONS	CODE NO	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
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SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 5146

	STANDARD
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM \$	559
PREMIUM DISCOUNT	NONE
0900-29 EXPENSE CONSTANT	200
TERRORISM RISK INS ACT 2002	56
TOTAL ESTIMATED PREMIUM	815
TAXES AND SURCHARGES	38
TOTAL ESTIMATED COST	853MP

A/R (WCIP) #

Minimum Premium: \$ 226

DEPOSIT PREMIUM: \$ 301

DATE OF ISSUE: 05-07-04 KL
OFFICE: ORLANDO DA HTFD 05G
PRODUCER: AMERICA S INS CENTER 2B3BR

ST ASSIGN: NJ



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (B)

POLICY NUMBER: (6S60UB-9589A89-3-04)

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

10456-NJ

INSURED'S NAME: W MANAGEMENT INC

RATE BUREAU ID: 144929

CLASSIFICATION	CODE	PREMIUM BASIS		ESTIMATED ANNUAL PREMIUM
		ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	
LOCATION 001 01				
FEIN 223769223 ENTITY CD 001				
NJ TAX IDENTIFICATION NO.: 223769223000				
W MANAGEMENT INC				
580 SYLVAN AVE				
ENGLEWOOD, NJ 07632				
CLERICAL OFFICE EMPLOYEES NOC	8810		.26	

3.30% EMPL. LIAB. INCREASED LIMITS (6199)	\$	16
ADD FOR INCREASED LIMITS MINIMUM (9848)		59
EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM		NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		559
EXPENSE CONSTANT(0900)		200
TERRORISM RISK INS ACT 2002 (9740)		56
6.79% 0935 NJ SECOND INJURY FUND SURCHARGE		38
0.20% 0936 NJ UNINSURED EMPL FUND SURCHARGE		NONE
TOTAL ESTIMATED PREMIUM		853
TOTAL ESTIMATED COST		853

DATE OF ISSUE: 05-07-04 KL

ST ASSIGN: NJ

SCHEDULE NO: 1 OF LAST



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: (6S60UB-9589A89-3-04)

LISTING OF ENDORSEMENTS
EXTENSION OF INFO PAGE

We agree that the following listed endorsements form a part of this policy on its effective date.

WC 00 00 01 B - 001	INFORMATION PAGE
WC 00 00 01 B - 001	INFORMATION PAGE 2
WC 00 00 01 B - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 99 06 49 00 - 001	EMPLOYERS LIABILITY LIMITS OF LIABILITY
WC 00 04 20 00 - 001	TERRORISM RISK INS ACT ENDT
WC 29 03 06 A - 001	NJ PART TWO EMPLOYERS LIABILITY ENDT.

THE HARTFORD

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who Is Insured

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational dis-

ease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE – WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;

2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law.

Enforcement may be against us or against you and us.

4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
 - a. benefits payable by this insurance;
 - b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO – EMPLOYERS LIABILITY INSURANCE**A. How This Insurance Applies**

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. We Will Pay

We will pay all sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. for which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. for care and loss of services; and
3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

4. because of bodily injury to your employee that arises out of and in the course of employment,

claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by you;
6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions.
8. bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901-942), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws.

9. bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51-60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws.
10. bodily injury to a master or member of the crew of any vessel.
11. fines or penalties imposed for violation of federal or state law.
12. damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801-1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. interest on a judgement as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is ex-

hausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. Limits of Liability

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below:

1. **Bodily Injury by Accident.** The limit shown for "bodily injury by accident—each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. **Bodily Injury by Disease.** The limit shown for "bodily injury by disease—policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease—each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgement.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE—OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.
3. We will reimburse you for the benefits required by the workers compensation law of that state if

we are not permitted to pay the benefits directly to persons entitled to them.

4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR – YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE – PREMIUM**A. Our Manuals**

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. All your officers and employees engaged in work covered by this policy; and
2. All other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy

ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short-rate cancellation table and procedure. Final premium will not be less than the minimum premium.

F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX – CONDITIONS**A. Inspection**

We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While

they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. Long Term Policy

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. Transfer of Your Rights and Duties

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.

2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

3. The policy period will end on the day and hour stated in the cancellation notice.

4. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

E. Sole Representative

The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancellation.

In witness whereof, the company has caused this policy to be signed by its President and Secretary at Hartford, Connecticut, and countersigned on the information page by a duly authorized agent of the company.

C. M. O'Halloran

Secretary

Ramani Ayer

President

WC00 00 00 (A)



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 99 06 49 (00)**

POLICY NUMBER: (6S60UB-9589A89-3-04)

EMPLOYERS LIABILITY LIMITS OF LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because New Jersey is shown in Item 3.A. of the Information Page.

1. The applicable limits of liability stated in Item 3.B. of the New Jersey Information Page WC 00 00 01 (B) and the limits of liability stated in the Countrywide Information Page WC 00 00 01 (A) of this policy refer to ONE AND THE SAME set of limits for Bodily Injury by Accident, Each Accident, Bodily Injury by Disease, Policy Limit; and Bodily Injury by Disease, Each Employee.
2. All other references to Part Two (Employers Liability Insurance) limits of liability within the policy remain unchanged.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 20 (OO)**

POLICY NUMBER: (6S60UB-9589A89-3-04)

TERRORISM RISK INSURANCE ACT ENDORSEMENT

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002.

Definitions

The definitions provided in this endorsement are based on the definitions in the Act and are intended to have the same meaning. If words or phrases not defined in this endorsement are defined in the Act the definitions in the Act will apply.

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002 and any amendments.

"Act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States as meeting all of the following requirements:

- a. The act is an act of terrorism.
- b. The act is violent or dangerous to human life, property or infrastructure.
- c. The act resulted in damage within the United States, or outside of the United States in the case of United States missions or certain air carriers or vessels.
- d. The act has been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

"Insured terrorism or war loss" means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at United States missions or to certain air carriers or vessels.

"Insurer deductible" means:

- a. For the period beginning on November 26, 2002 and ending on December 31, 2002, an amount equal to 1% of our direct earned premiums, as provided in the Act, over the calendar year immediately preceding November 26, 2002.
- b. For the period beginning on January 1, 2003 and ending on December 31, 2003, an amount equal to 7% of our direct earned premiums, as provided in the Act, over the calendar year immediately preceding January 1, 2003.
- c. For the period beginning on January 1, 2004 and ending on December 31, 2004, an amount equal to 10% of our direct earned premiums, as provided in the Act, over the calendar year immediately preceding January 1, 2004.
- d. For the period beginning on January 1, 2005 and ending on December 31, 2005, an amount equal to 15% of our direct earned premiums, as provided in the Act, over the calendar year immediately preceding January 1, 2005.

Limitation of Liability

The Act may limit our liability to you under this policy. If annual aggregate insured terrorism or war losses of all insurers exceed \$100,000,000,000 during the applicable period provided in the Act, and if we have met our insurer deductible, the amount we will pay for insured terrorism or war losses under this policy will be limited by the Act, as determined by the Secretary of the Treasury.

Policyholder Disclosure Notice

1. Insured terrorism or war losses would be partially reimbursed by the United States Government under a formula established by the Act. Under this formula, the United States would pay 90% of our insured terrorism or war losses exceeding our insurer deductible.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 20 (OO)**

POLICY NUMBER: (6S60UB-9589A89-3-04)

2. The additional premium charged for the coverage this policy provides for insured terrorism or war losses is shown in Item 4 of the Information Page or the Schedule below.

Schedule			
State	Rate per \$100 of Remuneration	State	Rate per \$100 of Remuneration
NEW JERSEY	0.030		

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 29 03 06 (A)**

POLICY NUMBER: (6S60UB-9589A89-3-04)

NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because New Jersey is shown in Item 3.A. of the Information Page.

With respect to ~~Exclusion C7~~ we will defend any claim, proceeding or suit for damages where bodily injury is alleged. We have the right to investigate and settle. We will not defend or continue to defend after the applicable limits of the insurance have been paid. Such policy limits include any legal costs assessed against you on behalf of your employee(s).

We may not limit our liability to pay damages for which we become legally liable to pay because of bodily injury to an infant under the age of 18 years in a proceeding made pursuant to Article 2 as provided in N.J.S.A. 34:15-10.

This insurance does not provide for the payment of any common law negligence damages or other damages when the provisions of Article 2 of the New Jersey Workers Compensation Law have been rejected by you and your employee(s) as provided in N.J.S.A. 34:15-9.

With respect to paragraph F., the "Other Insurance" provision is replaced with the following:

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

This insurance, however, is excess over any other applicable insurance with respect to claims for bodily injury arising out of employer practices, policies, acts or omissions enumerated in C-7 above, whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise.

WORKSHEET FOR WORKERS' COMPENSATION TELEPHONE REPORTING

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:

Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL OF THE QUESTIONS**ACCOUNT INFORMATION**

CALLER'S PHONE NUMBER/EXTENSION ()	CALLER'S NAME (FIRST, MI., LAST)	CALLER'S TITLE	BENEFIT STATE
EMPLOYER'S NAME	EMPLOYER'S ADDRESS (STREET, CITY, STATE & ZIP)	EMPLOYER'S MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME	
PARENT COMPANY/INSURED'S NAME	LOCATION CODE	NATURE OF BUSINESS	POLICY FORM (6S60UB-9589A89-3-04)

EMPLOYEE INFORMATION

EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER
EMPLOYEE'S MAILING ADDRESS (STREET, CITY, STATE & ZIP)	IS EMPLOYEE'S HOME ADDRESS THE SAME? IF NO, STREET, CITY, STATE & ZIP <input type="checkbox"/> YES <input type="checkbox"/> NO	
MARITAL STATUS	EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NO. OF DEPENDENTS
	CLASS CODE	DATE OF BIRTH
	WAGE PERIOD	HOME PHONE NUMBER ()

ACCIDENT INFORMATION

DATE OF INJURY	TIME OF INJURY A.M. P.M.	DATE CLAIM REPORTED TO EMPLOYER	WAS THE ACCIDENT ON THE EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
LOCATION OF ACCIDENT ADDRESS (STREET, CITY, STATE & ZIP)			COUNTY	
DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? IF YES, DATE RETURNED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE EMPLOYEE LAST WORKED	WAS EMPLOYEE PAID FOR DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE EMPLOYEE LAST PAID
DATE DISABILITY BEGAN	DATE DISABILITY ENDED	IS / WAS EMPLOYEE'S SALARY CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS EMPLOYEE'S INJURY RELATED TO A COMPANY-SPONSORED EVENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS ACCIDENT FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO
FULL DESCRIPTION OF ACCIDENT				

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)	IF MOTOR VEHICLE ACCIDENT, DRIVER'S LICENSE NUMBER	STATE WHERE ISSUED
CONTRIBUTING FACTORS	EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED	
IF OTHER PARTIES WERE INVOLVED NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

WERE SAFEGUARDS PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DESCRIPTION OF SAFEGUARDS	WERE SAFEGUARDS USED? <input type="checkbox"/> YES <input type="checkbox"/> NO
WITNESS INFORMATION NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

INJURY INFORMATION

PART OF BODY INJURED (E.G. HEAD, NECK, ARM, LEG)	NATURE OF INJURY (E.G. FRACTURE, SPRAIN, LACERATION)	PREVIOUS RELATED CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRE-EXISTING MEDICAL CONDITION(S)
CUMULATIVE INJURY? IF YES, LENGTH OF EXPOSURE <input type="checkbox"/> YES <input type="checkbox"/> NO	NATURE OF DUTIES	LENGTH OF TIME DOING ACTIVITY	
TREATMENT ("X" ALL THAT APPLY) <input type="checkbox"/> FIRST AID -	NAME (FIRST, MI, LAST)	WHAT TYPE OF FIRST AID WAS ADMINISTERED?	1ST DAY OF TREATMENT
<input type="checkbox"/> HOSPITAL/ <input type="checkbox"/> CLINIC -	NAME AND ADDRESS (STREET, CITY, STATE & ZIP)	TREATMENT	LENGTH OF STAY
<input type="checkbox"/> PHYSICIAN -	NAME AND ADDRESS (STREET, CITY, STATE & ZIP)	PHONE NUMBER ()	SPECIALTY
		TREATMENT	1ST DAY OF TREATMENT

EMPLOYEE JOB INFORMATION

EMPLOYEE'S OCCUPATION WHEN INJURED:

IS THIS EMPLOYEE'S REGULAR OCCUPATION?

OCCUPATION IS: ☐ SEDENTARY ☐ LIGHT ☐ MEDIUM ☐ HEAVY

EMPLOYEE'S REGULAR WORK HOURS: HOURS/DAY DAYS/WEEK

EMPLOYEE'S PAY: \$ /HOUR; OR \$ /WEEK

DOES EMPLOYEE RECEIVE ADD'L BENEFITS (e.g. Overtime, Uniforms, Meals, etc.)?

EMPLOYEE'S DATE OF HIRE:

EMPLOYEE'S SUPERVISOR:

SUPERVISOR'S PHONE NUMBER: () SUPERVISOR'S REGULAR WORK HOURS:

STATE SPECIFIC INFORMATION

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS
FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS**Alabama**

Employee's county
 Employer's ID (U.C. Account) Number
 Specific product (e.g., tires)

Alaska

Side of body affected (left or right)
 Employer's Alaska address (if different from mailing address)
 Date and time employee left work
 Scheduled days off
 Time workday began
 Was accident caused by failure of a machine or product?
 If injury was caused by a mechanical part, specify part
 If the accident was caused by anyone besides employee, give name and address
 If fatal, name and address of dependents
 If you doubt validity of claim, state reason
 Alaska Unemployment Insurance Account Number (U.I. Acct. No.)

Arizona

Last date of work after injury
 Number of days per week company usually works
 Department number
 If validity of claim is doubted, state reason
 If another person not employed by company caused accident, give name and address
 Was worker in your employ when injured?
 Hours per day employee worked the day of injury
 Will work loss exceed 7 days?
 Was injured paid for the day of injury? (If yes, specify amount)
 Was employee hired for permanent employment?
 Number of months employment available during the year
 Is employee furnished lodging or board? (If yes, specify value)
 Does employee claim dependents?
 Actual gross earnings of employee for the 30 calendar days preceding injury
 Is employee paid other than fixed weekly or monthly salary?
 Does employee earn extra pay for overtime? (If yes, basis of payment/hourly amount)
 Number of hours overtime considered normal per week
 Has injured been employed for more than 12 months?
 Gross wages of employee during 12 months preceding injury (from-through/amount)
 Gross wages of employee from date of hire through date of accident
 Has employee received a wage increase within 12 months prior to injury? (If yes, specify date, wage/per before and wage/per after increase)
 Gross earnings from date of increase through day prior to injury
 Was employee in overtime when injured?

California

State Unemployment Insurance Account Number
 Type of employer (private/state/city/county/school district/other government)
 Was employee unable to work for at least one full day after the date of injury?
 Date employee was provided claim form

Colorado

How long has employee worked for this employer?
 Employee's length of experience at this assignment
 Years of education completed (6 to 20)
 Number of employees
 If employee has not returned to work, estimate date of return
 Did injury occur because of intoxication, failure to use safety devices, failure to obey rules?
 Will benefits continue during disability?
 If employee's health insurance benefits discontinue, what will the weekly cost be for continuing such benefits?
 If fatal, give name, relationship and address of closest dependent of deceased
 Is employee receiving overtime, commissions or piecework?

Connecticut

Reason for report (lost time/medical-health care/occupational disease/correct prior report)
 Time employee's workday began
 Extent of accident/health and life coverage for employee
 For Occupational Disease Only
 Date of last exposure
 Date of diagnosis as occupationally related
 Employer's Registration Number (CRN)
 Was employee treated in an emergency room?

Delaware

Employer's UC Reporting Number
 Employee's county
 If employee has returned to work, at same wage?

District of Columbia

If employee has returned to work, at what time?
 Was injured hired in DC?
 Was injured given Form #7 DCWC?
 Piece or time worker

Florida

Time injury was reported
 Rate of pay / per
 Was physician/hospital authorized by employer?
 Does the employer agree with the description of accident?
 Did the employee knowingly refuse to use safety equipment provided by you, the employer?
 Did the employee request medical care? (If yes, did the employer provide medical care?)

Georgia

Specific products (e.g., tires)

Hawaii

Was employee furnished meals or lodging?
 Monthly salary
 Department of Labor Number
 Medical deductible

Idaho

If gratuities (tips, etc.) were received in the course of employment, estimate weekly value
 Length of time employed by you at this occupation
 If mechanical apparatus or vehicle caused injury, what part of it caused injury?
 Type of treatment (inpatient/outpatient)
 If fatal, name and address of nearest relative
 What was employee doing when the accident occurred?

Illinois

Illinois Unemployment Compensation Number
 SIC Number
 Total number of employees at the location where illness or injury occurred
 Was employee given Industrial Commission Handbook?
 Did incident result in occupational injury or occupational disease?
 What unsafe act by a person caused or contributed to the injury or illness?

Indiana

Number of lost workdays to date

Iowa

Number of employees
 Was injury caused by failure to use safety equipment or observe regulations?
 If employee has not returned to work, probable length of disability
 Is the injury expected to produce permanent disability?

WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS

Exemption information (employee/spouse/over 65/blind/other dependents)

Does employee receive earnings other than cash? (Does not include expense reimbursement) (If yes, list weekly value of housing, meals, other)

Does employee normally receive the same gross wages each pay period?

If YES - Are earnings based on hourly wages? (If no, indicate weekly earnings and how computed)

If NO - Does employee have more than 13 weeks completed employment with your firm? (If yes, total earnings for last completed period of 13 weeks) (If no, estimate employee earnings had 13 weeks been completed by employee)

What was employee doing when injured or exposed?

Kansas

SIC Number

If worker was admitted to hospital, date of admission

Was worker treated in emergency room only?

If employee has returned to work, was return to light duty?

Is further medical treatment needed?

If compensation is now being paid, date of initial payment

If fatal, name and address of dependents

Kentucky

If this case was OSHA recordable, reason for recording (e.g. loss of consciousness)

Unemployment Insurance ID Number

Specify products or service comprising majority of sales (e.g. ski boots)

Department where working when injury occurred

Commission or piece work earnings - in how many hours in the past 12 months

Number of scheduled work days lost to date

Did injury or illness cause restriction of duty or permanent transfer to another job?

If fatal, give name and address of next of kin

Louisiana

Employer's Federal ID Number

Employer's Unemployment Insurance Reporting Number

If employee has returned to work, at same wage?

Did injury occur because of mechanical defect or unsafe act?

Did injury cause amputation?

If occupational disease, date of initial diagnosis

Employee parish (county)

Maine

Employer's Unemployment Insurance Account (UIAN)

Reason for report (lost time/medical-health care/occupational disease/correct prior report)

Does employee work for another company?

For Occupational Disease only

Date of last exposure

Date of diagnosis as occupationally related

Maryland

Type of ownership - individual/partnership/corporation/other (if other, specify)

Unemployment Number

Specific products (e.g., tires)

Is the employee an officer or partner?

If under age 18, Certificate Number

Exemption information (employee/spouse/over 65/blind/other dependents)

Does employee receive pay in kind? (if yes, explain)

SIC Code Number

Massachusetts

Industry Code Number if the average 52 week wage was given, indicate whether it is an estimated or actual amount

Self-Insured? (if yes, Self-Insurer Number)

First day of total or partial incapacity to earn wages

Fifth day of total or partial incapacity to earn wages

If employee has returned to work, did employee return to his/her regular occupation?

Describe nature of business or article manufactured

Employee's department and floor number

Michigan

If employee is under 18 years of age, work permit date

Tax filing status (single/single, head of household/married, filing jointly/married, filing separately)

If employee works for second employer, specify name and address

Average weekly wage

Federal ID Number

Total gross weekly wages (highest 39 of 52)

Number of weeks used when calculating gross weekly wages

Value of discontinued fringe benefits

Was employee a volunteer worker?

Was employee certified as vocationally handicapped?

If employer is a temporary service agency, specify name and address of employer where accident occurred

Minnesota

Was employee an apprentice?

Was employee furnished meals or lodging in addition to wages?

If employee has other regular employment, indicate weekly wage

Unemployment ID Number

SIC Number

Mississippi

Type of business (corporation/partnership/individual)

Specific products (e.g., tires)

If fatal, name and address of nearest relative

If married, spouse's name

Probable length of disability

List normally scheduled days off

Did employee work the next day following injury?

Time employee discontinued working

If employee is paid on commission or piece work basis, average weekly amount

If board, lodging or other advantages were furnished, average weekly amount

Missouri

Specific products (e.g., tires)

Was there any dismemberment, disfigurement or other permanent disability? (If yes, state nature)

Actual or estimated cost of medical treatment

Is further medical treatment required?

Nebraska

Normal hours per day/week

Number of days per week

Name and address of principal dependent or friend

Length of time at present occupation

Was the employee working on overtime?

Is any permanent disability anticipated?

Unemployment Insurance Account Number

Did employer provide or authorize medical attention?

What was employee actually doing when injured?

Nevada

Is injured worker a corporate officer, sole proprietor or partner?

Was worker in your employ when injured?

Number of work days lost

How might this accident have been prevented?

If injury was not fatal, did accident result in loss of consciousness, restriction of work or motion, transfer to another job, termination or none of these?

Will employer have light duty available?

Last date wages were earned

Is employee furnished lodging or board? (If yes, monthly value of lodging or board)

If validity of claim is doubted, state reason

WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS

Does the employee receive either piecework or commission?
 Does the employee declare tips as income?
 Employer's Account Number

New Hampshire

If under age 18, is there a Child Labor Employment Certificate on file?
 Was injured hired in New Hampshire?
 Piece or time worker
 Time disability began
 Has injured filed a Form 8a WCA?
 Part of machine on which accident occurred?
 Kind of power (e.g., hand, foot, electrical, steam, etc.)
 Was accident caused by injured's failure to use or observe safety equipment or regulation?
 Probable length of disability
 If employee has returned to work, at what time?
 Federal I.D. Number
 Has employee returned to full or light duty?
 Initial treatment (none, employer, emergency, hospitalized, outpatient, clinic or office visit)
 If employee is a leased or temporary worker, client's business name is there a managed care program? (If yes, name of provider)
 Is there a written safety program in force?
 Is there an active safety committee?
 Number of employees, full time and part time
 SIC Code

New Jersey

Number of employees
 Was employee unable to work on any day after the injury?
 SIC Number
 Employer's Registration Number

New Mexico

Federal ID Number
 NM Unemployment Insurance Number
 Does your business have a safety program? (If yes, specify administered period - weekly/monthly/ annually/other - if other, specify)
 Highest educational level attained
 Total lost work days
 If occupational illness, date diagnosed and description of diagnosis
 Was employee under the influence of drugs/alcohol? (Yes/no/unknown)

New York

Code Number
 NYS U.I. Employer Registration Number
 Total earnings paid during 52 weeks prior to date of accident (include bonuses, overtime, value of lodging, etc.)
 Did employer provide medical care? (If yes, when?)
 Has the injury/illness been previously reported on Form C-2.1?
 Indicate days of week that employee regularly works
 If fatal, name, address and relationship of nearest relative

North Carolina

Employer Code Number
 Time disability began
 Kind of power (hand, foot, electrical, steam, etc.)
 Part of machine on which injury occurred
 Was accident caused by injured's failure to use or observe safety equipment or regulation?
 Probable length of disability
 If employee has returned to work, at what time?

North Dakota

Will employee be off the job for five or more consecutive days?
 Time employee left work due to this injury
 Time workday began on the day of injury
 If employee has not returned to work, estimate date of return
 Employee's gross total earnings for the past 52 weeks

List each dependent under age 18, or under age 22 if attending school, or incapable of self support (name, birth date and relationship)
 Exact location of injury (e.g., plant, department, building, etc.)
 Workers Compensation Account Number
 Season length (in months)

Ohio

Time accident reported to employer
 Has employee ever filed a previous application for this injury?
 Has employee filed any other claims with the Bureau or Industrial Commission? (If yes, specify claim number and body parts)
 Employee's county
 Employer's Risk Number
 If under your employ for less than 12 months prior to injury, list former employers, dates if employment, wages and number of weeks

Oklahoma

SIC Number

Oregon

Education (number of years completed, or GED)
 Side of body affected (left or right)
 Department regularly employed
 Type of employer (individual/corporation/partnership/other)
 Is worker an owner or corporate officer?
 Did injury occur during the course of employment?
 Was accident caused by failure of machinery or product?
 Did someone (not worker) cause accident?
 Time worker left work
 Explain if number of hours per shift or week varies
 Scheduled days off

Pennsylvania

Employer's Unemployment Compensation Reporting Number
 If employee has returned to work, at what wage?
 Employee's county
 If employee is under age 18, Certificate Number and occupation for which issued
 Did injury occur because of mechanical defect or unsafe act?
 Was employee amputated?

South Dakota

Federal ID Number
 Unemployment Number
 SIC Code Number
 Number of employees
 Is the employee an officer or partner?
 Time workday began
 Exemption information (employee/spouse/over 65/blind/other dependents)
 Does employee receive pay in kind? (If yes, explain)
 Type of treatment (outpatient, emergency room or in house)
 Injury Codes:
 Body part injured (2 digits)
 Cause of injury (2digits)
 Nature of injury (2digits)

Tennessee

Federal ID Number
 If paid on other than a time basis, such as piece work or commissions, indicate method and actual average weekly earnings
 If board, lodging or other advantages were furnished in addition to wages, state nature and estimated weekly value
 If employee has returned to work, at what wage?
 If fatal, name and address of nearest relative

Texas

Federal Tax ID Number
 Does the employee speak English? (if no, specify language)
 Employee's mailing county
 If married, spouse's name

WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS

Work site location of injury (e.g., stairs, dock, etc.)
 Was employee hired or recruited in Texas?
 Is the employee an owner, partner or corporate officer?
 SIC Number
 Texas Comptroller Taxpayer Number
 Did you request accident prevention services in the past 12 months?
 (If yes, did you receive them?)

Vermont

Federal ID Number
 Specific products
 Was employee hired in Vermont?
 Does the employer regularly employ 10 or more employees?
 Machine or tool involved in the accident
 Was machine described defective? (If yes, describe how)
 Can the employer prevent this type of accident? (If yes, describe how)
 Could the injured have prevented the accident? (If yes describe how
 - do not reply by stating "By being more carefull - be specific)
 If fatal, name, address and relationship to nearest relative

Virginia

Did accident occur on state property?
 Time incapacity began
 Was employee paid on a piece work or hourly basis?
 Value of perquisites per week (food/meals, lodging, tips, other)
 Specify part of machine or tool causing injury or illness
 Probable length of disability
 Federal Tax ID Number

Washington

If married, full name of spouse at time of injury (if divorced, give final decree date)
 Employee's height and weight
 Name, birth date and relationship of children under 18 supported by employee
 Side of body affected (left or right)
 Does employee have more than one paying job?
 Describe what employee was doing when injured?
 How long has the employee worked for you?
 Was employee doing his/her regular work when injured?
 Where did accident occur? (employer's premises, employer's parking lot, other)
 In your opinion, was the accident caused in any way by someone not employed by you?
 If the employer is different than the one where injured, give name and address
 Average daily earnings from piece work, tips and/or commissions as reported to the IRS
 If reporting of accident was delayed, specify why
 Was accident caused by failure of a machine or product?
 Has the employee ever been treated for similar injury before? (if yes, describe injury)

West Virginia

County in which employee lives
 Time employee began work on the day of injury
 Time employee stopped work due to injury
 Is employee still under a doctor's care?
 Is employee presently receiving workers' compensation benefits?
 What was employee's daily rate of pay on date of injury?
 Is employee owner or part owner of business? If yes, do you include his/her wages on your quarterly payroll report?
 Wage information: 60, 180 and 365 days prior to date of injury
 Do you disagree with any of the information provided? (If yes, explain)
 Estimate how long employee will be off work (no lost time/less than 4 days/one week)
 Do you have any reason to question this injury? (If yes, explain)
 Are you the injured worker?
 Is your supervisor aware of your injury?

Wisconsin

Type of business (individual/partnership/corporation)
 If employee has not returned to work, estimate date of return
 If employee is under age 18, was permit filed?
 Did injury occur because of intoxication, failure to use safety devices or obey rules?
 Did injury occur in the course of worker's employment?
 In addition to wages, did employee receive board, room, tips?
 (Average amount weekly)
 If fatal, provide name, relationship and address of closest dependent of deceased
 For the quarter in which injury occurred and the 3 preceding quarters, report the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.
 If piece work, number of hours
 Employee's scheduled work week when injured (Start time, hours per day, hours per week and days per week)
 Is the employee a full time employee?
 Part-time information: Are there other part-time workers doing the same work with the same hours? (If yes, how many?)
 Number of full-time employees doing the same work

Wyoming

Type of employee (regular employee/volunteer worker/corporate office/JTPA/owner of business/partner/inmate/independent contractor)
 Is employee provided with housing and/or food that he will lose due to injury? (If yes give fair market rental of house, monthly average for food)
 Employee's gross monthly earnings
 Is employee paid travel expenses?
 Date of diagnosis
 Work days lost or days of restricted activity due to injury
 Side of body affected (left or right)
 Does employer certify that injury occurred on premises used, controlled or occupied by him or her, that the injury occurred at work and arose out of and in the course of the worker's employment and that he believes the injury to be compensable? (If no, specify)

U.S. Longshoreman (USDOL)

Under what Act is injury reported? Longshore and Harbor Workers' Compensation Act/Defense Base Act/Nonappropriated Fund Instrumentalities Act/Outer Continental Shelf Lands Act)
 Indicate where injury occurred (aboard vessel or over navigable waters/pier or wharf, dry dock/marine terminal/building way/marine railway/other adjoining area)
 Did injury cause loss of time beyond day or shift of accident?
 If employee returned to work, at what hour?
 Date and hour employee first lost time because of injury
 Did employee stop work immediately?
 Was employee doing usual work when injured/killed?
 Date and hour pay stopped
 Name days usually worked by employee
 How was knowledge of accident or occupational illness gained?
 Exact place where accident occurred (specify area if accident was maritime employment and occurred in area adjoining navigable waters)
 Was first treating physician chosen by employee?
 Has medical attention been authorized? (If yes, date of authorization)



WORKERS COMPENSATION TELEPHONE REPORTING

Dear Employer,

We are pleased to offer you a toll-free telephone reporting service to report employee injuries. This service has been designed to **save you time, reduce paperwork, and reduce the cost of worker's compensation insurance.**

The rising cost of workers compensation insurance is of concern to you and other employers in your state, as it is to Travelers. Travelers has made this service available so that we can better control claim costs and reduce the ever growing costs of the workers compensation system.

The number is 1-800-832-7839

Studies have shown that injured workers reassured that their medical and lost time costs will be covered are less likely to seek assistance from outside of the system. This reduces costs while helping return Workers Compensation to its original purpose as a direct delivery system for injured workers. Additionally, employer involvement and concern for their injured employee has accelerated the employee's return to work, reducing costs even further.

We have taken this step with our customers serviced by the Travelers in your state to demonstrate our continued commitment to provide the highest level of service to all of our customers.

Please review the enclosed material. You will find that it is easy to follow and use. Your producer has also received a copy of this information and may wish to advise you further about this service and how it can have a positive effect on the cost of workers compensation insurance.

If you would like more information about this program or any other services available from The Travelers please contact our Service Center.

Sincerely,

The Travelers

WORKERS' COMPENSATION TELEPHONE REPORTING 1-800-832-7839

TO REPORT A WORKERS' COMPENSATION CLAIM

When an employee is injured, the most important thing is to secure appropriate medical treatment. Once this has been done, the claim should be called into The Travelers.

Suggested Steps:

1. Gather the facts.

Use the GUIDE FOR REPORTING WORKERS' COMPENSATION CLAIMS as a reference. It is not necessary to write answers to questions you know, it is a tool to help reduce the amount of time you are on the telephone.

Remember, the objective is to report the claim quickly. We need the employee's name, social security number and a description of the accident. Try to gather as much information as possible, but don't worry if you do not have the answers to each and every question.

2. Call the Customer Service Unit.

We have a single telephone number and the call will automatically be routed to the proper regional Customer Service Unit. You will be greeted on the telephone by a Customer Service Representative, who will complete the state specific notice of injury on the system by asking you the necessary questions. The order of the questions will be the same every time you call.

The questions are grouped into three sections:

- **General Questions**

This section contains questions specific to you, your employee and the accident. Once you have reported a claim, the system will prefill your employer specific information, such as your policy number on all future claims.

- **State Specific Questions**

If the jurisdiction requires data not covered in the general section, it will be covered here.

- **Additional Comments and Information**

If you would like to provide additional information not covered elsewhere, the Customer Service Representative will be able to record this in a free form area.

3. Let Your Employee Know.

Before you hang up, the Customer Service Representative will give you a claim number.

Referencing the claim number will help expedite the handling of the rest of the claim. Please include the claim number with all future correspondence, such as wage statements or medical bills. Please be sure to give this number to your employee.

ATTENTION

NOTICE TO POLICYHOLDERS

**IF YOU HAVE EMPLOYEES WHO TRAVEL OR WORK
OUT OF STATE, YOU MAY NEED ADDITIONAL
WORKERS' COMPENSATION INSURANCE.
CONSULT YOUR INSURANCE ADVISOR OR CARRIER
PRIOR TO COMMENCEMENT OF OPERATIONS IN
ANY STATE NOT LISTED ON YOUR POLICY.**

IMPORTANT
Policy Audit Information

Dear Policyholder:

This policy is issued with an estimated premium based upon information provided through your Producer. This premium is subject to adjustment at the end of the policy period. At that time, you may receive a request for information in the mail or a premium auditor may contact you to review the necessary records. The information developed is needed to determine the final earned premium for this policy.

Record Maintenance

In order to facilitate audit service, it is necessary to maintain proper records and have them available at the proper time. Based on the nature of your business, some of the following data will be necessary to complete the audit:

1. General Ledger, Financial Statements
2. Payroll Records, Time Books, State Unemployment Returns, FICA Returns, Individual Earnings Records-Monthly totals separated by type of work and overtime.
3. Cash Receipts, Sales Journal
4. Cash Disbursements Journal - Including subcontractors, casual labor and material costs.
5. Certificates of Insurance

IMPORTANT COVERAGE NOTE:

If you utilize subcontractors whose legal status is that of sole proprietor/partner, we may charge premium for these persons as provided under Part 5 of the policy contract even though certificates of insurance may exist. Please contact your producer if you have any questions regarding your Workers' Compensation coverage needs.

Work in Other States

Please advise your Producer if employees are hired for work in states other than those listed in Item 3. of your policy. This will enable your producer to consider your need for coverage in accordance with state laws.

We appreciate the opportunity to serve you. If you have any questions about the enclosed policy or any insurance matters please contact your producer or your Company representative.

NOTICE

The Information Page of your Workers' Compensation and Employers Liability Insurance Policy contains line items for (1) a Second Injury Fund Surcharge and (2) and Uninsured Employer's Fund Surcharge. Each surcharge amount represents a percentage of your total estimated standard premium and will be subject to adjustment when the final audited standard premium is determined. Explanations of these surcharges are provided below.

SECOND INJURY FUND

The New Jersey Workers' Compensation Law established the Second Injury Fund to provide benefits to workers who become permanently and totally disabled as a result of work-related injury or occupational disease when that worker had been previously partially disabled. The Law also requires that the Fund provide annual adjustments to certain persons permanently and totally disabled and to certain dependents of deceased workers.

Through 1988, the Second Injury Fund was financed by an annual assessment upon insurance carriers. Such assessment was included in your standard premium via the manual premium rate(s) shown in your policy Information Page.

Effective January 1, 1989 an amendment to the Law requires that the present financing be replaced by a direct surcharge shown as a separate "Second Injury Fund Surcharge" line on your policy Information Page. It will no longer be included in the manual premium rate. This new system will discourage other states from imposing retaliatory taxes on New Jersey based insurance companies and ultimately aid cost containment efforts.

UNINSURED EMPLOYERS FUND

The New Jersey Workers Compensation Law requires every employer to provide workers' compensation coverage through purchase of a workers' compensation and employers liability insurance policy. Failure to provide such coverage results in a fine and/or criminal action by the Department of Labor as well as continued liability for benefit payments to an injured worker.

The Uninsured Employers Fund was established by Law to provide benefits to an injured worker when the employer has failed to comply with the insurance provisions of the Law and is unable to provide the required benefits. Through 1988 total financing of the Fund was derived from fines imposed upon uninsured employers.

Effective January 1, 1989 an amendment to the law, requires that the present financing be supplemented by a direct surcharge shown as a separate "Uninsured Employers Fund Surcharge" line on your policy Information Page. This method will assure the delivery of benefits to injured workers and the surcharge will cease whenever the year end balance of the Fund exceeds \$500,000.

NOTICE

Dear Policyholder:

Effective January 1, 1999, the State of New Jersey, Commissioner of Banking and Insurance approved the following change to your Workers' Compensation and Employers Liability Policy.

- * The elimination of Endorsement WC 29 03 01, the New Jersey Part Two Limit of Liability Endorsement.
 - * The inclusion of Endorsement WC 29 03 06, the New Jersey Part Two Employers Liability Endorsement.
-

The above revisions serve to:

- * Impose a limit on our liability under Part Two, Employers Liability.
- * Recognize the litigious environment involving claims alleging discrimination, harassment etc. and discourage such activities in the workplace.

Note: these changes are mandatory and apply to every standard New Jersey Workers' Compensation and Employers Liability Insurance Policy.

No coverage is provided by this policyholder notice nor can it be construed to replace any provision of your policy. You should read your policy and review your Information Page for complete information on coverage you are provided.

If additional information is needed, please contact your producer or broker.

NOTICE

Dear Policyholder:

The enclosed Workers Compensation Policy has been issued to you showing two Information Pages. They both will reflect the total of your policy estimated premium. The reason for the two Information Pages for your account is because New Jersey requires its own Information Page. The New Jersey Information Page has its own version identifier different from the countrywide identifier.

There is absolutely no additional premium for the account due to the additional Information Page. We need this separation to handle statutory requirements and statistical separation of New Jersey Workers Compensation premium from the other states on the policy.

The addition of this New Jersey Information Page does not Add to or Subtract from any coverages that are on your policy.

Thank you for your understanding in this matter.

The Travelers



NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with

HARTFORD UNDERWRITERS INSURANCE COMPANY

Insurance Company

for the period

Beginning 04-17-04 **Ending** 04-17-05

Employer W MANAGEMENT INC

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.



AVISO

El patron avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revision de estatutos del Estado de New Jersey, asegurandolos con

HARTFORD UNDERWRITERS INSURANCE COMPANY

Compañia de Seguro

por el periodo

Comenzando 04-17-04 **Terminando** 04-17-05

Patron W MANAGEMENT INC

De acuerdo con la ley mencionada arriba, esta noticia debe ser colocada y mantenida en un lugar visible en todos los lugares de trabajo.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: (6S60UB-9589A89-3-04)

FOR PRODUCER ONLY, BILLING SCHEDULE BY COMMISSION RATE

INSTALLMENT DUE DATE	AMOUNT	COMMISSION RATE
04-17-04	\$ 294	.0000
04-17-04	\$ 559	.0800

THE AMOUNTS ABOVE WILL BE BILLED SEPARATELY.

DATE OF ISSUE: 05-07-04

ST ASSIGN: NJ



IMPORTANT NOTICE

Dear Producer,

Travelers has a toll-free telephone reporting system for workers compensation claims.

The number is 1-800-832-7839.

Telephone reporting is a valuable aid benefiting all parties. It reduces paper-work and claims handling time. Most importantly, it allows Travelers to immediately take charge of the claim with our managed care program. Early involvement by the employer and a Travelers claims case manager, will serve to speed an injured worker's return to work and lower overall claim costs.

Your assistance in advising your insured about the value of this service in reducing claim costs will help Travelers form the essential coalition of employer, producer and servicing company.

If you would like more information about this program or any other services available from The Travelers please contact our Service Center.

Travelers is committed to providing the highest quality of service to their customers and appreciates your cooperation in these efforts.

Sincerely,

The Travelers



SAFETY SERVICES

Notice to policy recipient: If you are not the person directly responsible for the accident prevention activities for your company, please direct this Safety Services notice to the person that is directly responsible for them.

SAFETY IS OUR CONCERN

Thank you for purchasing your Workers' Compensation insurance. Along with your agent, we appreciate your business and welcome the opportunity to be of service.

An important part of that service concerns accident prevention and safety engineering. Our Loss Prevention & Engineering Division has the experience, resources and capabilities to provide a range of safety services including site surveys, phone consultations or the provision of selected safety material. The following are some examples of our available services:

Accident Prevention - Our staff can help you identify present and potential safety hazards in your operations, premises and equipment, recommending measures for reducing or eliminating these hazards.

Analysis of Accident Causes - Although you investigate and keep records of accidents, we're available to help if needed.

Safety Consultations - Our field staff, supported by Home Office and field specialists, can help you with special problems such as ergonomics.

Industrial Hygiene/Health Services - We have the facilities and resources to answer your questions concerning job related industrial hygiene/health issues and to measure exposure to industrial hygiene hazards.

Safety Videos and Literature - We can provide you with basic videos and literature to assist you in your loss control efforts. Also, we can put you in contact with several companies able to provide additional safety materials including brochures, pamphlets and videos.

Safety Training - We can help you improve your safety training programs.

Internet Website - Visit the Loss Prevention & Engineering website page for helpful safety information. (<http://www.travelerspc.com/safety>). This website also has hot links to other safety-related Internet sites. For all requests for loss control assistance ONLY, please directly contact your local office listed on the following pages

The Travelers will provide these services upon request. Telephone consultation is also available if the nature of the operations and hazards warrant such service. See the rest of this document for the Loss Prevention & Engineering office nearest to you.

SAFETY IS YOUR CONCERN

U. S. employers spend billions of dollars each year on the direct and indirect costs of work-related accidents. Dollar figures can't begin to reflect the pain and suffering of an injured worker and his or her family. But they do give some indication of the multiple consequences of a job-related accident... loss of time, interrupted production, damaged materials and equipment, the expense of retraining or replacing an injured worker, possible legal action from government regulatory agencies, and increased insurance costs.

It makes good sense for both employers and their employees to actively participate in a sound accident prevention program. The success of such a program depends to a large extent on your commitment to safety procedures and accident prevention techniques. Safety is a management concern. Maybe we can help.

You may want to consider the following "Safety Checkpoints" as you evaluate your organization's safety activities:

SELF-INSPECTION PROGRAM:

- * Do you conduct periodic surveys of premises?... equipment?... operations?
- * Do you analyze each job to find inherent hazards?
- * If you discover hazards, do you follow up with immediate corrective action?
- * Do you monitor such action to make sure it is implemented and effective?

ACCIDENT INVESTIGATION:

- * Do you investigate each accident?...determine the cause?
- * Do you take immediate steps to prevent a recurrence?
- * Do you keep records of accident investigations and follow-up measures?
- * Do you complete accident statistics and analyze trends?

EDUCATION AND TRAINING

- * Do you take the time to train each of your employees to perform tasks safely?
- * Do more-experienced employees receive training to correct bad habits that have developed over time?
- * Do all employees understand that safety is an important part of their jobs?

**FIELD OFFICE INFORMATION FOR SAFETY SERVICES ONLY****ALABAMA**

Birmingham
3000 Riverchase Galleria,
Suite 600
Birmingham, AL 35244
(205) 982-4583

ALASKA

Portland, OR
4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
(503) 534-4276

ARIZONA

Phoenix
2401 W Peoria Ave., Suite 130
Phoenix, AZ 85029
(602) 861-8649

ARKANSAS

Dallas
1301 E Collins Blvd., Suite 300
Richardson, TX 75081
(214) 570-6194

CALIFORNIA

Diamond Bar
21688 Gateway Center Drive
P.O. Box 6512
Diamond Bar, CA 91765-8512
(909) 612-3500

Glendale
700 N. Central Avenue, 8th Floor
P.O. Box 1840
Glendale, CA 91209
(818) 409-4220

Los Angeles
880 South Figueroa St., Suite 500
Los Angeles, CA 90017
(213) 533-3682

Sacramento
11090 White Rock Road
Rancho Cordova, CA 95670
(916) 638-6404

San Diego
9325 Sky Park Court, Suite 220
San Diego, CA 92123
(858) 616-6285

Walnut Creek
225 Lennon Lane, Suite 200
P.O. Box 8090
Walnut Creek, CA 94596-8090
(925) 945-4171

COLORADO

Denver
7600 E. Orchard Rd., Suite 380
Englewood, CO 80111
P.O. Box 173713
Greenwood Village, CO 80111
(303) 740-1691

CONNECTICUT

Hartford
300 Windsor Street
Hartford, CT 06120
(860) 277-5980

DELAWARE

Baltimore
8013 Corporate Drive
White Marsh, MD 21236-4975
(410) 931-5159

DISTRICT OF COLUMBIA

Washington, DC
14048 Park East Circle
Chantilly, VA 20151
(703) 818-6765

FLORIDA

Orlando
Gtwy Ctr-1000 Legion Place,
10th Floor
P.O. Box 3555
Orlando, FL 32802-3555
(407) 649-2596

GEORGIA

Atlanta
4400 North Point Parkway
2nd Floor
Alpharetta, GA 30022
(770) 521-3020

HAWAII

Diamond Bar
21688 Gateway Center Drive
P.O. Box 6512
Diamond Bar, CA 91765-8512
(909) 612-3500

IDAHO

Portland, OR
4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
(503) 534-4276

ILLINOIS

Chicago
190 S. LaSalle Street Suite 960
Chicago, IL 60603
(312) 609-2936

Naperville
215 Shuman Boulevard
P.O. Box 3208
Naperville, IL 60566
(630) 961-8074

INDIANA

Indianapolis
6081 E. 82nd St.,
P.O. Box 50485
Indianapolis, IN 46250-0485
(317) 841-2966

IOWA

Kansas City
7600 College Blvd.
Overland Park, KS 66210
(913) 661-3679

KANSAS

Kansas City
7600 College Blvd.
Overland Park, KS 66210
(913) 661-3679

KENTUCKY

Louisville
305 North Hurstbourne Pkwy,
Suite 125
Louisville, KY 40222
(502) 423-5447

LOUISIANA

New Orleans
3900 N. Causeway, Suite 950
Metairie, LA 70002
P.O. Box 61479
New Orleans, LA 70161-1479
(504) 832-7560

MAINE

Portland, ME
207 Larrabee Road, Suite 3
Westbrook, ME 04092
(207) 857-2021

MARYLAND

Baltimore
8013 Corporate Drive
White Marsh, MD 21236-4975
(410) 931-5159

MASSACHUSETTS

Boston
100 Summer Street, Suite 201A
Boston, MA 02110
(617) 984-1284

Hudson
1 Cabot Road, Suite 200
Hudson, MA 01749
(617) 984-1284

Quincy
300 Crown Colony Drive
Quincy, MA 02169
P.O. Box 943
Boston, MA 02103-0943
(617) 984-1284

MICHIGAN

Grand Rapids
3777 Sparks Ave., SE, Suite 200
P.O. Box 3010
Grand Rapids, MI 49501-0323
(616) 942-4344

Southfield
26555 Evergreen Rd., Suite 1240
Southfield, MI 48076-4385
(248) 423-2299

**FIELD OFFICE INFORMATION FOR SAFETY SERVICES ONLY (Cont'd)****MINNESOTA**

Minneapolis
6465 Wayzata Blvd., 5th Floor
P.O. Box 35
Minneapolis, MN 55440-0035
(952) 541-4265

MISSISSIPPI

New Orleans
3900 N. Causeway, Suite 950
Metairie, LA 70002
P.O. Box 61479
New Orleans, LA 70161-1479
(504) 832-7560

MISSOURI

St. Louis
One City Place Drive
Creve Coeur, MO 63141
P.O. Box 66852
St. Louis, MO 63166-6852
(314) 994-2374

Kansas City
7600 College Blvd.
Overland Park, KS 66210
(913) 661-3679

Missouri Workers' Compensation Plan (MWCP)

951 Hornet Drive
P.O. Box 42021
Hazelwood, MO 63042-2309
(314) 551-3208

MONTANA

Portland, OR
4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
(503) 534-4276

NEBRASKA

Omaha
11422 Miracle Hills Drive, Suite 110
Omaha, NE 68154
(913) 661-3679

NEVADA

Las Vegas
1850 E Flamingo, Suite 202
Las Vegas, NV 89119
(702) 669-4718

NEW HAMPSHIRE

Portland, ME
207 Larrabee Road, Suite 3
Westbrook, ME 04092
(207) 857-2021

NEW JERSEY

Morris Plains
1100 American Road, 2nd Floor
Morris Plains, NJ 07950
(973) 606-5245

Pennsauken
4350 Haddonfield Road
Pennsauken, NJ 08109
(856) 488-5942

NEW MEXICO

Dallas
1301 E Collins Blvd., Suite 300
Richardson, TX 75081
(214) 570-6194

NEW YORK

Albany
900 Watervliet-Shaker Road
Albany, NY 12205
(315) 424-7231

Buffalo
60 Lakefront Blvd.
P.O. Box 242
Buffalo, NY 14240-0242
(315) 424-7231

East Meadow
90 Merrick Ave., 4th Floor
East Meadow, NY 11554-1593
(973) 606-5245

New York
One Whitehall Street
New York, NY 10004-2108
(973) 606-5245

Rochester
75 Town Centre Drive
P.O. Box 23235
Rochester, NY 14692-3235
(315) 424-7231

Syracuse
440 South Warren Street
P.O. Box 4963
Syracuse, NY 13221-4963
(315) 424-7231

NORTH CAROLINA

Charlotte
11440 Carmel Commons Blvd.
P.O. Box 473500
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895 Central Avenue, Suite 800
Cincinnati, OH 45202
(216) 348-7512

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(216) 348-7512

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9820 East 41st Street, Suite 401
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(913) 661-3679

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4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
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5001 Louise Drive
Mechanicsburg, PA 17055
(717) 691-5101

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1500 Market Street
29th Floor W Tower
Philadelphia, PA 19102
(267) 675-3056

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Pittsburgh, PA 15219-2502
(412) 338-3082

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(610) 371-3809

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Quincy, MA 02169
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Richardson, TX 75081
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Chantilly, VA 20151
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